



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

PETER G FOOX MD

**Respondent Name**

SAFETY NATIONAL CASUALTY CORP

**MFDR Tracking Number**

M4-14-0372-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

September 27, 2013

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Please note our bill for this date is attached to this report. By accepting this report, you accept receipt of the HCFA 1500 in a timely fashion. Do not separate the bill from the narrative report."

**Amount in Dispute:** \$578.71

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 8, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 22, 2013	CPT Code 99455-V5-WP	\$578.71	\$450.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1 – Workers Compensation State Fee Schedule Adjustment
  - 309 – The charge for this procedure exceeds the fee schedule allowance
  - 600 – Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description

## Issues

1. Is the requestor entitled to reimbursement?

## Findings

1. The services in dispute are for maximum medical improvement and impairment rating examinations.

Per 28 Texas Administrative Code §134.204(j)(3)(A)(i) states "Reimbursement shall be the applicable established patient office visit level associated with the examination. (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit."

Provider billed with service code 99455-V5-WP in the amount of 800.00 with two units.

The maximum allowable reimbursement for maximum medical improvement is \$221.29.

Per 28 Texas Administrative Code §134.204(j)(1)(4)(C)(ii)(II) states "If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area."

Review of the submitted documentation provided supports a full physical evaluation to two body areas (knee and lumbar spine) with range of motion method used.

The maximum allowable reimbursement (MAR) for the impairment rating on the two body parts is \$450.00.

The total combined reimbursement for maximum medical improvement and impairment rating examination is \$671.29.

The respondent issued payment in the amount of \$221.29. Therefore, an additional amount of \$450.00 is recommended.

## Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$450.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$450.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	2/27/15 Date
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## **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**